GREATER ATTLEBORO–TAUNTON REGIONAL TRANSIT AUTHORITY (GATRA)

STATEWIDE ACCESS PASS

AND

ADA PARATRANSIT ELIGIBILITY

APPLICATION FORM

PART B:

TO BE COMPLETED BY PHYSICIAN OR AGENCY PROFESSIONAL

Dear Health Care Professional:

The Americans with Disabilities Act of 1990 (ADA) is a civil rights law which bans discrimination against people with disabilities. To meet their needs, public bus companies must provide a variety of services.

You have been requested by your patient/client to provide information to the Greater Attleboro–Taunton Regional Transit Authority (GATRA) regarding his/her ability to use our transit services. Federal law requires that the Greater Attleboro–Taunton Regional Transit Authority (GATRA) provide paratransit service (Dial-A-Ride) to persons who cannot use our fixed-route bus service.

Please understand that the law is quite strict in defining who is eligible for this specialized service. A person must have an actual physical or mental functional limitation which prohibits their use of accessible fixed-route public transportation.

The information that you provide describing the physical and mental capabilities of this person allows us to make an appropriate evaluation of his/her application in keeping with the requirements of the law and the best interests of the applicant. All information on this form will be kept confidential.

The processing of this person's application cannot be completed until we receive this information from you. Thank you for your assistance.

How does this person's disability or disabilities cause functional limitations that adversely affect his/her mobility?

Is this condition _____ Permanent

Temporary _____ Expected duration is _____ months

Can applicant climb stairs? _____Yes _____No

Read Survival Signs? _____Yes _____No

Hear Spoken Directions? _____Yes _____No

Is applicant able to take the regular fixed-route bus service? *(All of GATRA's buses are wheelchair accessible.)* _____Yes _____No _____Sometimes

Explanation:

If applicant has a vision impairment, please complete the following:

Vision Acuity with best correction:
Right Eye Left Eye Both Eyes

Visual Fields:
Right Eye Left Eye Both Eyes

Can the applicant read informational signs? _____Yes _____No

Able to cross busy streets and intersections? _____Yes _____No

Is applicant able to use regular fixed-route bus service despite his/her visual impairment?
_____Yes _____No _____Sometimes

If no or sometimes, please explain:

_____

_____

_____

_____

If this person has a cognitive disability, please complete the following:

Is he/she able to:

Give their name, address and telephone number upon request?	_____Yes	_____No
Recognize a destination or landmark?	_____Yes	_____No
Deal with unexpected situations or unexpected changes in routine?	_____Yes	_____No
Ask for, understand and follow directions?	_____Yes	_____No
Safely and effectively travel through crowded and/or complex facilities?	_____Yes	_____No

Please describe any other functional limitation(s) affecting this person's mobility that are not described above:

_____

_____

_____

_____

IMPORTANT — SEE BACK PAGE!

PROFESSIONAL CERTIFICATION AND VERIFICATION

I certify that this information is correct to the best of my knowledge.

DATE: _____

PROFESSIONAL SIGNATURE: _____

LICENSED MASS I.D. NUMBER: _____

PHONE: _____

PATIENT NAME: _____

Please mail completed form to:

GATRA
2 Oak Street
Taunton, MA 02780
Attn: Joan Gallagher